Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

NATIONAL QUALITY MEASURES CLEARINGHOUSE

General

Title

Language services: the percent of patient visits and admissions where preferred written language for health care is screened and recorded.

Source(s)

Robert Wood Johnson Foundation. Aligning forces for quality. Language services performance measures implementation guide, version 1.1. Washington (DC): George Washington University; 2009 Aug. 84 p.

Measure Domain

Primary Measure Domain

Process

The validity of measures depends on how they are built. By examining the key building blocks of a measure, you can assess its validity for your purpose. For more information, visit the Measure Validity page.

Secondary Measure Domain

Does not apply to this measure

Brief Abstract

Description

This measure is used to assess the percent of patient visits and admissions where preferred written language for health care is screened and recorded.

Rationale

Hospitals cannot provide adequate language services to patients if they do not create mechanisms to screen for limited English-proficient patients and record patients' preferred written language for health care. Standard practices of collecting preferred written language for health care would assist hospitals in planning for demand. Access to and availability of patient language preference is critical for providers in planning care. This measure provides information on the extent to which patients are asked about the

language they prefer to read health care materials and the extent to which this information is recorded.

Primary Clinical Component

Limited English proficiency (LEP); preferred written language; screening

Denominator Description

The total number of hospital admissions, visits to the emergency department, and outpatient visits (see the related "Denominator Inclusions/Exclusions" field)

Numerator Description

The number of hospital admissions, visits to the emergency department, and outpatient visits where preferred written language for health care information is screened and recorded (see the related "Numerator Inclusions/Exclusions" field)

Evidence Supporting the Measure

Evidence Supporting the Criterion of Quality

A formal consensus procedure involving experts in relevant clinical, methodological, and organizational sciences

One or more research studies published in a National Library of Medicine (NLM) indexed, peer-reviewed journal

Evidence Supporting Need for the Measure

Need for the Measure

Variation in quality for the performance measured

Evidence Supporting Need for the Measure

Hakimzadeh S, Cohn D. English usage among Hispanics in the United States. Pew Hispanic Center, The Henry J. Kaiser Family Foundation; 2007.

Hasnain-Wynia R, Pierce D. HRET disparities toolkit: a toolkit for collecting race, ethnicity, and primary language information from patients. The Health Research and Education Trust; 2005 Feb.

Pew Hispanic Center. Bilingualism (survey brief). The Henry J. Kaiser Foundation; 2004 Mar.

State of Use of the Measure

State of Use

State of Use

Pilot testing

Current Use

Collaborative inter-organizational quality improvement

Decision-making by managers about resource allocation

Internal quality improvement

Monitoring and planning

Quality of care research

Application of Measure in its Current Use

Care Setting

Ambulatory Care

Hospitals

Physician Group Practices/Clinics

Professionals Responsible for Health Care

Measure is not provider specific

Lowest Level of Health Care Delivery Addressed

Group Clinical Practices

Target Population Age

All ages

Target Population Gender

Either male or female

Stratification by Vulnerable Populations

Non-English Populations can be identified from screening to determine if needed translations services were delivered. Diagnostic codes can be stratified by language to identify priority language for translating patient education materials.

Characteristics of the Primary Clinical Component

Incidence/Prevalence

Incidence/Prevalence

- 22.3 million U.S. residents (8.4%) have limited English proficiency (LEP).
- Between 1990 and 2000, the number with LEP grew by 53%.
- 80% of hospitals reported treating LEP patients on a regular basis.

Evidence for Incidence/Prevalence

Flores G. Language barriers to health care in the United States. N Engl J Med. 2006 Jul 20;355(3):229-31. PubMed

Hasnain-Wynia RJ, Yonek R, Pierce D, Kang GC. Hospital language services for patients with limited English proficiency: results from a national survey. The Commonwealth Fund; 2006 Oct.

U.S. Bureau of the Census. American Community Survey: language spoken at home (table S1601). 2005.

Association with Vulnerable Populations

- Hispanics who do not speak English at home are less likely to receive all recommended health care services.
- Follow-up compliance, adherence to medications, and patient satisfaction are significantly lower for limited English-proficient (LEP) populations than they are for English speaking patients.
- Language barriers are associated with less health education, worse interpersonal care, and lower patient satisfaction.
- LEP populations are less likely to receive preventative health services such as mammograms.

Evidence for Association with Vulnerable Populations

Andrulis D, Goodman N, Pryor N. What a difference an interpreter can make: health care experiences of uninsured with limited English proficiency. The Access Project; 2003 Apr.

Cheng EM, Chen A, Cunningham W. Primary language and receipt of recommended health care among Hispanics in the United States. J Gen Intern Med. 2007 Nov;22 Suppl 2:283-8. PubMed

David RA, Rhee M. The impact of language as a barrier to effective health care in an underserved urban Hispanic community. Mt Sinai J Med. 1998 Oct-Nov;65(5-6):393-7. PubMed

Ku L, Waidmann T. How race/ethnicity, immigration status and language affect health insurance coverage, access to care and quality of care among the low-income population. Washington (DC): Kaiser Commission on Medicaid and the Uninsured; 2003 Aug. 29 p.

Ngo-Metzger Q, Sorkin DH, Phillips RS, Greenfield S, Massagli MP, Clarridge B, Kaplan SH. Providing high-quality care for limited English proficient patients: the importance of language concordance and interpreter use. J Gen Intern Med. 2007 Nov;22 Suppl 2:324-30. PubMed

Woloshin S, Schwartz LM, Katz SJ, Welch HG. Is language a barrier to the use of preventive services. J Gen Intern Med. 1997 Aug;12(8):472-7. PubMed

Burden of Illness

- Persons with limited English proficiency (LEP) experience disproportionately high rates of infectious disease and infant mortality.
- Persons with LEP are more likely to report risk factors for serious and chronic diseases such as diabetes and heart disease.

See also the "Association with Vulnerable Populations" field.

Evidence for Burden of Illness

Office of Minority Health and Health Disparities. Eliminating racial and ethnic disparities.

Utilization

See the "Association with Vulnerable Populations" field.

Costs

- Physicians who are unable to communicate effectively with their patients often compensate by engaging in costly practices such as: more diagnostic procedures; more invasive procedures; overprescribing medications.
- Language barrier between physicians and their patients are associated with a $38 increase in test charges and 20-minute longer emergency department (ED) stay.
- ED decision making behavior (e.g., diagnostic testing, admission, IV hydration) is more costly when non-English speaking patients did not receive care from bilingual physician or with an interpreter present.
- The average cost per interpretation for health maintenance organizations (HMOs) patients was $79 and the total cost per year was $279, a relatively small cost given total medical expenditures, and given improved patient utilization of preventive and primary care services that may reduce long-term medical costs.

Evidence for Costs

Hampers LC, Cha S, Gutglass DJ, Binns HJ, Krug SE. Language barriers and resource utilization in a pediatric emergency department. Pediatrics. 1999 Jun;103(6 Pt 1):1253-6. PubMed

Hampers LC, McNulty JE. Professional interpreters and bilingual physicians in a pediatric emergency department: effect on resource utilization. Arch Pediatr Adolesc Med. 2002 Nov;156(11):1108-13. PubMed

Jacobs EA, Shepard DS, Suaya JA, Stone EL. Overcoming language barriers in health care: costs and benefits of interpreter services. Am J Public Health. 2004 May;94(5):866-9. PubMed

Ku L, Flores G. Pay now or pay later: providing interpreter services in health care. Health Aff (Millwood). 2005 Mar-Apr;24(2):435-44. PubMed

Institute of Medicine (IOM) Healthcare Quality Report

Categories

IOM Care Need

Getting Better

Living with Illness

Staying Healthy

IOM Domain

Effectiveness

Equity

Patient-centeredness

Data Collection for the Measure

Case Finding

Users of care only

Description of Case Finding

All hospital admissions, visits to the emergency department, and outpatient visits

Denominator Sampling Frame

Patients associated with provider

Denominator Inclusions/Exclusions

Inclusions
The total number of hospital admissions, visits to the emergency department, and outpatient visits, including:

- Scheduled and unscheduled visits
- Elective, urgent and emergent admissions
- Short stay and observation patients
- Transfers from other facilities

Exclusions
None

Relationship of Denominator to Numerator

All cases in the denominator are equally eligible to appear in the numerator

Denominator (Index) Event

Encounter

Institutionalization

Denominator Time Window

Time window is a single point in time

Numerator Inclusions/Exclusions

Inclusions
The number of hospital admissions, visits to the emergency department, and outpatient visits where preferred written language for health care is screened and recorded, including:

- Admissions and visits where the patient's preferred written language for health care is recorded
- Admissions and visits where the patient declined to answer the screening question

Note: The admissions and visits are stratified by language, including English, decline, or unavailable.

Exclusions
Admissions and visits where the written language preference data is not recorded

Measure Results Under Control of Health Care Professionals, Organizations and/or Policymakers

The measure results are somewhat or substantially under the control of the health care professionals, organizations and/or policymakers to whom the measure applies.

Numerator Time Window

Encounter or point in time

Data Source

Administrative data

Medical record

Registry data

Level of Determination of Quality

Individual Case

Pre-existing Instrument Used

Health Research and Educational Trust Disparities Toolkit

Computation of the Measure

Scoring

Rate

Interpretation of Score

Better quality is associated with a higher score

Allowance for Patient Factors

Analysis by high-risk subgroup (stratification on vulnerable populations)

Description of Allowance for Patient Factors

Data reported as aggregate numerator and denominator, monthly, stratified by written language preference, including English, decline or unavailable.

Standard of Comparison

Internal time comparison

Evaluation of Measure Properties

Extent of Measure Testing

The measure is currently being tested in nine grantee hospitals in the Aligning Forces for Quality Language Quality Improvement Collaborative (LQIC) in both inpatient and outpatient care settings from July 2009 - October 2010. The 9 LQIC hospitals range in size from 7,000-50,000 annual admissions includes one children's hospital, and include rural and academic and non-academic community hospitals.

The measure was adapted from the L1A: Screening for Preferred Spoken Language for Health Care, which was used by the 10 grantee hospitals in the Speaking Together National Language Services Collaborative from November 2006 - May 2008. The 10 hospitals reported data monthly on 40,000 - 60,000 patients seen in inpatient and ambulatory care settings. Hospitals ranged in size from 11,500 - 44,000 admissions, included 2 children's hospitals and were comprised of both academic teaching and non-teaching community hospitals.

Refer to original measure documentation for additional information.

Evidence for Reliability/Validity Testing

Robert Wood Johnson Foundation. Aligning forces for quality. Language services performance measures implementation guide, version 1.1. Washington (DC): George Washington University; 2009 Aug. 84 p.

Identifying Information

Original Title

L1B: screening for preferred written language for health care.

Measure Collection Name

Language Services Performance Measures

Submitter

Center for Health Care Quality, Department of Health Policy, George Washington University School of Public Health and Health Services - Academic Affiliated Research Institute

Developer

Center for Health Care Quality, Department of Health Policy, George Washington University School of Public Health and Health Services - Academic Affiliated Research Institute

Funding Source(s)

Robert Wood Johnson Foundation

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Financial Disclosures/Other Potential Conflicts of Interest

No disclosures.

Adaptation

Measure was adapted from another source.

Parent Measure

L1A: Screening for Preferred Spoken Language for Health Care [Center for Health Care Quality, Department of Health Policy, George Washington University School of Public Health and Health Services]

Release Date

2009 Jul

Measure Status

This is the current release of the measure.

Source(s)

Robert Wood Johnson Foundation. Aligning forces for quality. Language services performance measures implementation guide, version 1.1. Washington (DC): George Washington University; 2009 Aug. 84 p.

Measure Availability

The individual measure, "L1B: Screening for Preferred Written Language for Health Care," is published in "Aligning Forces for Quality. Language Services Performance Measures Implementation Guide."

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NQMC Status

This NQMC summary was completed by ECRI Institute on May 17, 2010. The information was verified by the measure developer on July 2, 2010.

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For additional information regarding the use of these measures, contact Catherine West at Cathy.West@gwumc.edu.

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